

# **COMMUNITY CARE LICENSING DIVISION**

*"Promoting Healthy, Safe and  
Supportive Community Care"*



## **TECHNICAL SUPPORT PROGRAM**

### **Self-Assessment Guide**

## **RESIDENTIAL CARE FACILITY FOR THE ELDERLY PREADMISSION QUESTIONNAIRE**



**CDSS**

CALIFORNIA  
DEPARTMENT OF  
SOCIAL SERVICES

**TECHNICAL SUPPORT PROGRAM**  
**RESIDENTIAL CARE FACILITY FOR THE ELDERLY**  
**PREADMISSION QUESTIONNAIRE**

The following questionnaire is designed to assist licensees in identifying specific medical and behavioral issues that may affect the placement of and/or services to be provided to prospective residents of Residential Care Facilities for the Elderly (RCFE). The questions on this form should be reviewed with the applicant's responsible party prior to admission to the facility. If the answer to any of the questions on this list is yes; the licensee should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs.

The information on this form supplements the Preplacement Appraisal Information form (LIC 603), but does not replace it. While the information gathered from this form should assist licensees in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Current Residence:  
Own home \_\_\_\_\_ With family \_\_\_\_\_ Board & Care \_\_\_\_\_ SNF \_\_\_\_\_ Hospital \_\_\_\_\_

Reason for Placement in RCFE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's Physician: \_\_\_\_\_

**A. INCIDENTAL MEDICAL SERVICES ASSESSMENT**

**YES**      **NO**

**1. Oxygen Administration**

☐      ☐ Does the applicant use oxygen? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (See 87703)

☐      ☐ Does the applicant need assistance? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Exception required. See 87703)

☐      ☐ Does the applicant use liquid oxygen? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (Exception required. See 87701(a)(12) policy)

## INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)

**YES**

**NO**

### 2. Intermittent Positive Pressure Breathing (IPPB) Machine

☐☐

Does the applicant use an IPPB? If yes, explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87704)

☐☐

Does the applicant need assistance? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (Exception required. See 87704)

### 3. Colostomy/Ileostomy

☐☐

Does the applicant have a colostomy or ileostomy? If yes, explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87705)

☐☐

Does the applicant need assistance? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (Exception required. See 87705)

### 4. Enema/Suppository/Fecal Impaction Removal

☐☐

Does the applicant need enemas, suppositories or fecal impaction removal? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87706)

☐☐

Does the applicant need assistance? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87706)

(Procedures must be performed by an Appropriately Skilled Professional [ASP])

### 5. Catheter Care

☐☐

Does the applicant have a catheter? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (See 87707)

☐☐

Does the applicant need assistance? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Exception may be required. See 87707)

**INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)**

**YES**      **NO**

**6. Bowel and Bladder Incontinence**

☐      ☐ Is the applicant incontinent of bowel or bladder? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87708)

**7. Contractures**

☐      ☐ Does the applicant have contractures? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87709)

☐      ☐ Does the applicant need assistance? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Exception required. See 87709)

☐      ☐ Do the contractures severely affect the applicant's ability to function?  
(If yes, not allowed in an RCFE. See 87709)

**8. Diabetes**

☐      ☐ Does the applicant have diabetes? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87710)

☐      ☐ Does the applicant require assistance with performing or reading  
glucose tests, drawing up injectable medications or administering  
injections? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Procedures must be performed by an ASP. See 87710)

## INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)

**YES**

**NO**

### 9. Injections

☐☐

Does the applicant need any injections? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
(See 87711)

☐☐

Does the applicant need assistance with drawing up and administering the injections? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
(Procedures must be performed by an ASP. See 87711)

### 10. Healing Wounds

☐☐

Does the applicant have any healing wounds? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Exception required. See 87713)

☐☐

Does the applicant have stage 1 or 2 dermal ulcers (bedsores)? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Exception required. See 87713)

☐☐

Does the applicant have stage 3 or 4 dermal ulcers? (If yes, not allowed in an RCFE. See 87713)

### 11. Bedridden

☐☐

Is the applicant bedridden? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(See 87582)

☐☐

Is the condition temporary (less than 14 days)? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(See 87582)

☐☐

Is the condition permanent or expected to last more than fourteen days? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Exception and bedridden fire clearance required. See H&S 1569.72)

## INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)

**YES**

**NO**

**12. Gastrostomy**

☐ ☐ Does the applicant have a gastrostomy? (If yes, not allowed in an RCFE. See 87701)

**13. Naso Gastric (NG) Tubes**

☐ ☐ Does the applicant have NG tubes? (If yes, not allowed in an RCFE. See 87701)

**14. Staph Infection**

☐ ☐ Does the applicant have a Staph or other serious infection? (If yes, not allowed in an RCFE. See 87701)

**15. Total Care**

☐ ☐ Does the applicant need total care (assistance with ALL activities of daily living - eating, bathing, dressing, grooming, toileting and transferring)?  
(If yes, not allowed in an RCFE. See 87701)

**16. Tracheostomies**

☐ ☐ Does the applicant have a tracheostomy? (If yes, not allowed in an RCFE. See 87701)

**17. Hospice**

☐ ☐ Is the applicant currently receiving hospice care? (If yes, not allowed in an RCFE. See 87716)

## B. PERSONS WITH DEMENTIA

**YES**

**NO**

☐ ☐ Does the applicant have Dementia?

☐ ☐ Is the applicant mentally able to respond to an emergency signal or instruction? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87724)

☐ ☐ Is the applicant mentally unable to respond to an emergency signal or instruction? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Exception or waiver required. See 87724)

### C. BEHAVIORAL ASSESSMENT

Does the applicant have a history of any of the following behaviors?

**YES**

**NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Physical assaultiveness   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Verbal assaultiveness   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Wandering   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Sexual assaultiveness, molestation or inappropriate sexual activity |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Disruptiveness (screaming, throwing things, argumentative)          |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Property destruction  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Careless disposal of smoking materials                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Stealing  |

If the answer to any of the above is yes, describe the behavior: \_\_\_\_\_

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Frequency and duration of the behavior(s): \_\_\_\_\_

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Approximate date of last occurrence: \_\_\_\_\_

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What seems to trigger the behavior: \_\_\_\_\_

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Strategies to deal with the behavior: \_\_\_\_\_

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## BEHAVIORAL ASSESSMENT (Continued)

Does the applicant have a history of any of the following behaviors?

**YES**

**NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Refusal to take medication              |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Refusal to get medical attention        |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Refusal to bathe or wear clean clothing |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Non-compliance with house rules         |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Self-abuse                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Suicide attempts or suicidal thoughts   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Depression                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Alcohol or drug abuse                   |

If the answer to any of the above is yes, describe the behavior: \_\_\_\_\_

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Frequency and duration of the behavior(s): \_\_\_\_\_

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Approximate date of last occurrence: \_\_\_\_\_

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What seems to trigger the behavior: \_\_\_\_\_

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Strategies to deal with the behavior: \_\_\_\_\_

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#### D. MISCELLANEOUS

YES    NO

- ☐    ☐ 1. Does the applicant currently use any prescription or over-the-counter medications? If yes, please list.

Medication Name	Strength	Dose	Times

- ☐    ☐ 2. Does the applicant currently use any prescription or over-the-counter medications on a PRN basis? If yes, please list. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(PRN letter signed by the applicant's physician required. See 87575(b)(c)(d))

- ☐    ☐ 3. Does the applicant have any emergency medication that must be kept with him/her or at bedside? If yes, please list. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MISCELLANEOUS (Continued)**

**YES**

**NO**

☐ ☐ 4. Will the applicant be willing to have all of his/her medications, including over-the-counter medications, centrally stored?

5. Does the applicant use any of the following devices?

☐ ☐ Glasses

☐ ☐ Dentures

☐ ☐ Hearing Aid

☐ ☐ Other \_\_\_\_\_

6. Does the applicant need assistance with any of the following?

☐ ☐ Eating. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ Bathing. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ Dressing. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ Grooming. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ Toileting. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Does the applicant use any of the following?

☐ ☐ Cane. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ Crutch. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ Walker. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ Wheelchair. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MISCELLANEOUS (Continued)**

**YES**      **NO**

☐      ☐ 8. Does the applicant have any paralysis? If yes, explain (site, degree, assistance needed) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐      ☐ 9. Is the applicant unable to transfer? If yes, describe assistance needed.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐      ☐ 10. Does the applicant require a special diet? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐      ☐ 11. Does the applicant have any skin condition or history of skin breakdown? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐      ☐ 12. Will the applicant require transportation to any appointments or events other than routine local medical appointments? If so, where and how often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant/Responsible Person: \_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_

Facility Representative: \_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_